New Hampshire

XENICAL® FOR HYPERCHOLESTEROLEMIA

NH Medicaid Prior Authorization Request Form

Fax: 1-888-603-7696 Phone: 1-866-675-7755

First Health Services

Date of Medication Request: ___ ___ /___ ___ /___ ___ ___ ___

Section I: Patient Information and Medication Requested

Name: (Last, First) _____

NH Medicaid Number: ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____

Date of Birth: ___ ___ /___ ___ /___ ___ ___ ___ Gender: ☐ Male ☐ Female

Drug Name: _____ Strength: _____

Dosing Schedule: _____ Length of Therapy: _____

Section II: Clinical History

1. Diagnosis for use of Xenical®: _____
   Note: Xenical® coverage for weight loss should be requested using the Anti-Obesity Prior Authorization form.
2. Is the patient 18 years of age or older? ☐ Yes ☐ No
3. Has the patient failed treatment due to an adverse event with:
   - HMG CoA Reductase Inhibitors? ☐ Yes ☐ No If yes, which one? _____
   - Fibric Acid Derivatives? ☐ Yes ☐ No If yes, which one? _____
   - Bile Acid Derivatives? ☐ Yes ☐ No If yes, which one? _____
   - Nicotinic Acid? ☐ Yes ☐ No If yes, which one? _____
4. Is there any additional information that would help in the decision-making process? If additional space is needed, please use another page. _____

Section III: Prescriber Information

Name: _____ DEA Number: ___ ___ ___ ___ ___ ___ ___ ___ ___

Phone Number: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___ Fax Number: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

I certify that the information provided is accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

_____
Signature of Prescribing Provider